		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026773

Facility Name: Parents & Friends of the SLC

Address: 1450 Caseyville Ave (Number) Swansea (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: 618-277-7730 **Fax #** 618-277-5423

IDPA ID Number: 37-1089886005

Date of Initial License for Current Owners: 01/01/1982

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
	[X] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code 501 C 3			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: Shirley Saia **Telephone Number:** 618-277-7730 x3309

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Chad M. Rollins
(Title) Executive Director

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,600	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	30,403			30,403	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,403			30,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.07%

D. How many bed-hold days during this year were paid by Public Aid?
262 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [ ] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/204

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	204,149	18,379	8,875	231,403		231,403		231,403			1
2	Food Purchase		149,928		149,928		149,928		149,928			2
3	Housekeeping	133,064	19,583	8,790	161,437		161,437		161,437			3
4	Laundry		9,200	18,862	28,062		28,062		28,062			4
5	Heat and Other Utilities			118,652	118,652		118,652		118,652			5
6	Maintenance	60,380	14,102	802	75,284		75,284		75,284			6
7	Other (specify):*											7
8	**TOTAL General Services**	397,593	211,192	155,981	764,766		764,766		764,766			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	1,703,173	45,435	62,168	1,810,776		1,810,776		1,810,776			10
10a	Therapy	12,821			12,821		12,821		12,821			10a
11	Activities	35,131	9,108	150	44,389		44,389		44,389			11
12	Social Services	23,912		1,935	25,847		25,847		25,847			12
13	Nurse Aide Training	99,371			99,371		99,371		99,371			13
14	Program Transportation		16,853		16,853		16,853		16,853			14
15	Other (specify):*	9,038	1,591		10,629		10,629		10,629			15
16	**TOTAL Health Care and Programs**	1,883,446	72,987	77,453	2,033,886		2,033,886		2,033,886			16
	C. General Administration											
17	Administrative	71,480		1,701	73,181		73,181	(1,701)	71,480			17
18	Directors Fees											18
19	Professional Services			32,787	32,787		32,787		32,787			19
20	Dues, Fees, Subscriptions & Promotions			15,000	15,000		15,000	(1,780)	13,220			20
21	Clerical & General Office Expenses	133,413	12,170	32,888	178,471		178,471		178,471			21
22	Employee Benefits & Payroll Taxes			529,122	529,122		529,122		529,122			22
23	Inservice Training & Education			4,430	4,430		4,430		4,430			23
24	Travel and Seminar			3,177	3,177		3,177		3,177			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,259	52,259		52,259		52,259			26
27	Other (specify):*			14,094	14,094		14,094	(14,094)				27
28	**TOTAL General Administration**	204,893	12,170	685,458	902,521		902,521	(17,575)	884,946			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,485,932	296,349	918,892	3,701,173		3,701,173	(17,575)	3,683,598			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Parents & Friends of the SLC #0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,500	51,500		51,500		51,500			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			51,500	51,500		51,500		51,500			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			229,476	229,476		229,476		229,476			43
44	**TOTAL Special Cost Centers**			229,476	229,476		229,476		229,476			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,485,932	296,349	1,199,868	3,982,149		3,982,149	(17,575)	3,964,574			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(1,701)	C17		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,780)	C20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	14,094			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 10,613		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 10,613		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Parents & Friends of the SLC

ID# 0026773

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ 1,701	17	1
2	Lobbying costs assoicated with Illinois Health			2
3	Care Association dues	1,780	20	3
4	Miscellaneous non allowable expenses	14,094		4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	17,575		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	1,701	0	0	0	0	0	0	0	0	0	0	1,701	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	1,780	0	0	0	0	0	0	0	0	0	0	1,780	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	3,481	0	0	0	0	0	0	0	0	0	0	3,481	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	3,481	0	0	0	0	0	0	0	0	0	0	3,481	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parents & Friends of the SLC # 0026773 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,481	0	0	0	0	0	0	0	0	0	0	3,481	45

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		H.O.ME # 2	Fairview Heights	SLC Enrichment Center	Swansea	To provide recreational opportunities to the severe & profound mentally disabled individual
		H.O.M.E. #1	Swansea			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parents & Friends of the SLC COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0026773

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,317 B. General Construction Type: Exterior Brick and Frame Frame Protected non combust Number of Stories single

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

SLC Enrichmnet Center-to provide recreational opportunities to the servere and profound developmentally disabled individual

This is a gymnasium (with no beds)

Square footage---7,528

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care		1979	$ 999	1
2					2
3	TOTALS			$ 999	3

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1984	1984	$ 303,400	$ 10,114	30	$ 10,114	$	$ 203,114	4
5			1984	1984	33,537		15			33,537	5
6											6
7											7
8											8
	Improvement Type**										
9	Building			1978	17,185		15			17,185	9
10	Various Improvements			1979	18,581		20			18,581	10
11	Metal Heater Guard-All pods			1981	5,815		15			5,815	11
12	Sport Court			1982	7,239		10			7,239	12
13	Playground Equipment			1982	10,364		10			10,364	13
14	Storage Building			1982	8,927		15			8,927	14
15	Water Heater-Pod 3			1984	2,065		15			2,065	15
16	Draperies-All Pods and Core Building			1984	22,352		10			22,352	16
17	Drainage System			1984	23,286		10			23,286	17
18	Concrete Sport Court			1984	6,564		10			6,564	18
19	Sidewalk-Core Building to Pod 2& 3			1984	1,050		10			1,050	19
20	Sidewalk-ERC to Maintenance Building			1984	1,632		10			1,632	20
21	Various Trees			1984	5,600		10			5,600	21
22	Parking Lot-Gravel ERC			1985	1,247		10			1,247	22
23	Asphalt Running Track			1985	8,185		10			8,185	23
24	Door/ERC building			1985	564	19	30	19		363	24
25	ERC Walk and Curb			1985	3,020		10			3,020	25
26	Pine Pavilion			1985	11,542		15			11,542	26
27	Security Alarm			1985	868		15			868	27
28	Gym divider			1985	1,600		5			1,600	28
29	Storage Shelves-Gym			1985	1,010		5			1,010	29
30	Central Vacuum System-All Buildings			1985	7,680		10			7,680	30
31	Drapes for Core Building			1985	3,031		10			3,031	31
32	Faucets			1985	2,160	108	20	108		2,052	32
33	Power Mixer Valve-Core Building			1985	561		10			561	33
34	ERC Parking Lot			1984	2,176		10			2,176	34
35	Reading Ligths-All Pods			1985	1,689		10			1,689	35
36	Sidewalk -Core Building to ERC			1984	1,900		10			1,900	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Light Fixtures-All Pods	1985	$ 145	$	10	$	$	$	37
38	Power Panel/Fire Alarm	1985	1,285	64	20	64			38
39	Bathroom fixtures-All Pods	1985	2,050		10				39
40	Fire Alarm System	1986	4,901	245	20	245			40
41	Windows-Pod replacement	1986	244		10				41
42	Landscaping	1986	892		10				42
43	Power Mixer Valve-Core Building	1986	214		10				43
44	Bathroom Vanities-All Pods	1986	465		10				44
45	Overhead Basketball Goal	1986	3,422		10				45
46	Draperies-Core Building (Business Office)	1986	254		10				46
47	Remodel Visitor Room-Core Building	1986	646		10				47
48	Light Fixtures-All Pods	1988	1,162		10				48
49	Heat Booster-Pod 5	1988	712		10				49
50	Door Pump/Motor-Core Building Electric Door	1988	858		10				50
51	Marble Counter Tops-All Pods	1989	1,818		10				51
52	Chrome Lava Faucets-All Pods	1989	1,800		10				52
53	Back Flow Preventor-Core Building (Waterlines)	1989	1,293		10				53
54	Booster Heater-Pod 7	1989	779		10				54
55	Water Heater-Pods 6 (Booster)	1990	760		10				55
56	Repair A/C (Core Building)	1990	2,198		5				56
57	Repair A/C-Pod 5	1990	1,239		5				57
58	New A/C-Pod 3	1990	3,525		10				58
59	Water Heater-Pod 2	1990	1,522		10				59
60	Water Heater-Pod 4 (Booster)	1990	760		10				60
61	Solid Core Doors-Pod 5	1990	619		10				61
62	Water Heater-Pod 6	1990	820		10				62
63	Water Heater-Pod 7	1991	1,592		10				63
64	Water Heater-Pod 3 (Booster)	1991	810		10				64
65	Circuit Breaker Box-Core Building	1991	679		10				65
66	A/C Unit-Compressor-Pod 2	1991	975		10				66
67	A/C Unit-Compressor Pod 5	1991	1,285		10				67
68	Fires Safety/Smoke Detectors-All Pods	1992	864		10				68
69	A/C Unit-Pod 7 (Unit 2)	1992	3,642		10				69
70	TOTAL (lines 4 thru 69)		$ 559,060	$ 10,550		$ 10,550	$	$ 414,235	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 559,060	$ 10,550		$ 10,550	$	$ 414,235	1
2	A/C Unit-Pod 4 (Unit 1)	1992	3,642		10			3,642	2
3	Vanities/Pod Bathrooms-All Pods	1992	3,305		10			3,305	3
4	Electric Heaters-Pod 2 (Boosters)	1992	810		10			810	4
5	Water Heaters- Pod 2 and 4	1993	5,491		10			5,491	5
6	A/C Unit-Pod 2 (unit 1)	1993	3,642		10			3,642	6
7	Windows-Pod Replacement	1991	400	3	10	3		400	7
8	Painted All Pods-Labor/Material	1994	10,644		5			10,644	8
9	Additional Smoke Detectors-All Pods	1994	575	4	10	4		575	9
10	Various Corrections to Code	1994	1,097	18	10	18		1,097	10
11	Water Heater-Pod 5 (booster)	1994	860	14	10	14		860	11
12	Water Heater-Pod 6	1995	1,950	195	10	195		1,901	12
13	A/C Unit-Pod 6 (Unit 2)	1995	3,953	395	10	395		3,656	13
14	A/C Unit-ERC (Classroom)	1996	1,774	177	10	177		1,640	14
15	Carpeting-All Pods	1996	38,806		7			38,806	15
16	Painted Pods/Touch Up (Labor and Materials)	1996	3,356		5			3,356	16
17	Water Heater-Pod 5	1996	2,032	203	10	203		1,693	17
18	Booster Heater-Pod 5	1996	951	95	10	95		792	18
19	Booster Heater-Spare	1997	952	95	10	95		824	19
20	Carpeting-Core Building	1997	6,041	575	7	575		6,041	20
21	Water Heater Booster-Dietary	1997	1,585	208	7	208		1,585	21
22	Walk in Freezer Repairs	1998	1,590	227	7	227		1,514	22
23	Water Heater-120 Gallon	1998	2,152	307	7	307		1,869	23
24	Water Heater-120 Gallon	2000	2,256	322	7	322		1,449	24
25	Gymnasium Roof	2000	21,635	1,442	15	1,442		5,889	25
26	Renovation of Pod 2	2001	66,904	9,558	7	9,558		38,232	26
27	Renovation of Pod 4	2001	7,746	1,107	7	1,107		3,598	27
28	Fire Supression System-Dietary	2002	2,740	391	7	391		815	28
29	Water Softener System	2004	1,960	280	7	280		280	29
30	Condensing Unit (3 1/2 ton)	2004	742	53	7	53		53	30
31	A/C Unit-Pod 2	2004	4,261	254	7	254		254	31
32	A/C Compressor Unit (Core Building)	2004	14,839	883	7	883		883	32
33									33
34	TOTAL (lines 1 thru 33)		$ 777,751	$ 27,356		$ 27,356	$	$ 559,831	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 97,938	$ 14,664	$ 14,664	$	5	$ 120,129	71
72	Current Year Purchases	37,764	3,197	3,197			3,197	72
73	Fully Depreciated Assets	340,066	1,146	1,146			335,027	73
74								74
75	TOTALS	$ 475,768	$ 19,007	$ 19,007	$		$ 458,353	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1999 Dodge Mini Van	1999	$ 15,004	$ 250	$ 250	$	5	$ 15,004	76
77	Patient Care	2000 Used Riding Mower	2001	750	150	150		5	400	77
78	Patient Care	1991 Chevy Astro Van-W/C Lift	2002	10,130	2,026	2,026		5	5,909	78
79	Patient Care	1991 Chevy Van-W/C Lift	2002	7,000	1,400	1,400		5	3,033	79
80	TOTALS			$ 32,884	$ 3,826	$ 3,826	$		$ 24,346	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,363,083	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,500	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 51,500	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,101,603	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 44

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 86

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	1,108	9,953		11,061
4	Clinical Wages	(b)		55,584		55,584
5	In-House Trainer Wages	(c)		32,726		32,726
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 1,108	$ 98,263	$	$ 99,371
10	SUM OF line 9, col. 1 and 2	(e)	$ 99,371			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ N/A

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	33
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	41

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10/3	visits		123	6,224		123	6,224	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	123	$ 6,224	$	123	$ 6,224	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Parents & Friends of the SLC **#** 0026773 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** ######## **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 524,956	$ 524,956	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	852,485	852,485	3
4	Supply Inventory (priced at cost)	8,452	8,452	4
5	Short-Term Investments			5
6	Prepaid Insurance	35,123	35,123	6
7	Other Prepaid Expenses	7,710	7,710	7
8	Accounts Receivable (owners or related parties)	144,204	144,204	8
9	Other(specify): NAT Reimbursement	49,500	49,500	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,622,430	$ 1,622,430	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	336,937	336,937	14
15	Leasehold Improvements, at Historical Cost	440,814	440,814	15
16	Equipment, at Historical Cost	666,969	666,969	16
17	Accumulated Depreciation (book methods)	(1,101,603)	(1,101,603)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 343,117	$ 343,117	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,965,547	$ 1,965,547	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 71,753	$ 71,753	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	238,428	238,428	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued W/H for Life Insurance	57	57	36
37	Accrued Expenses	20,295	20,295	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 330,533	$ 330,533	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 330,533	$ 330,533	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,635,014	$ 1,635,014	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,965,547	$ 1,965,547	48

***(See instructions.)**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,701,547	1
2	Restatements (describe):		2
3	**2003 Receivable for Nurse Aide Training Reimbursement**		3
4	**was overstated**	(50,574)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,650,973	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(15,959)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (15,959)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,635,014	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,900,675	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,900,675	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	44,590	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,590	23
	D. Non-Operating Revenue		
24	Contributions	4,300	24
25	Interest and Other Investment Income***	12,123	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,423	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	garnishment fees, form completion fees,		28
28a	returned check fees and miscellaneous income	4,502	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,502	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,966,190	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	764,766	31
32	Health Care	2,033,886	32
33	General Administration	902,521	33
	B. Capital Expense		
34	Ownership	51,500	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	229,476	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,982,149	40
41	**Income before Income Taxes (line 30 minus line 40)****	(15,959)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (15,959)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,714	1,765	$ 40,148	$ 22.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	14,400	15,033	255,933	17.02	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	8,562	8,683	66,645	7.68	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,253	1,426	12,821	8.99	8
9	Activity Director	2,074	2,214	25,264	11.41	9
10	Activity Assistants	1,096	1,149	9,866	8.59	10
11	Social Service Workers	1,948	2,125	23,912	11.25	11
12	Dietician					12
13	Food Service Supervisor	4,084	4,344	53,346	12.28	13
14	Head Cook	4,426	4,537	42,941	9.46	14
15	Cook Helpers/Assistants	1,205	1,466	12,403	8.46	15
16	Dishwashers	11,854	12,411	95,458	7.69	16
17	Maintenance Workers	4,639	5,198	60,380	11.62	17
18	Housekeepers	14,348	14,711	133,064	9.05	18
19	Laundry					19
20	Administrator	1,956	2,076	49,936	24.05	20
21	Assistant Administrator	1,048	1,158	21,544	18.60	21
22	Other Administrative	320	3,353	50,518	15.07	22
23	Office Manager	1,640	1,842	31,462	17.08	23
24	Clerical	1,833	1,938	16,729	8.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,198	7,765	101,105	13.02	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	133,647	142,571	1,323,785	9.29	30
31	Medical Records	1,801	1,801	16,908	9.39	31
32	Other Health C: NA Training Coor	2,097	2,223	32,726	14.72	32
33	Other(specify) Seamstress	1,149	1,203	9,038	7.51	33
34	TOTAL (lines 1 - 33)	224,292	240,992	$ 2,485,932 *	$ 10.32	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	163	$ 7,365	1/3	35
36	Medical Director	96	13,200	9/3	36
37	Medical Records Consultant				37
38	Nurse Consultant	77	1,683	10/3	38
39	Pharmacist Consultant	72	2,160	10/3	39
40	Physical Therapy Consultant	74	3,700	10/3	40
41	Occupational Therapy Consultant	223	11,175	10/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	105	6,290	10/3	43
44	Activity Consultant				44
45	Social Service Consultant	32	1,935	12/3	45
46	Other(specify) Psychologist	300	19,747	10/3	46
47	Psychiatrist	48	4,200	10/3	47
48					48
49	TOTAL (lines 35 - 48)	1,190	$ 71,455		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	232	6,944	10/3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	232	$ 6,944		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chad M. Rollins	Executive Director	0	$ 49,936
Melissa Sauerwein	Asst. Administrator	0	21,544
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 71,480

B. Administrative - Other

Description	Amount
Bank Charges	$ 1,701
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,701

C. Professional Services

Vendor/Payee	Type	Amount
Gallop, Johnson, Neuman	legal services	$ 14,182
Rice Sullivan & Co., Ltd.	audit services	9,750
SIDC	payroll services	4,754
Matthis-Marifian-Richter- Grandy	legal services	2,676
Nancy Montague	accounting services	1,425
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 32,787

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,745
Unemployment Compensation Insurance	17,663
FICA Taxes	193,670
Employee Health Insurance	215,413
Employee Meals	64,734
Illinois Municipal Retirement Fund (IMRF)*	
Employee Gifts	3,075
Employee Physicals	5,822
TOTAL (agree to Schedule V, line 22, col.8)	$ 529,122

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,000
Advertising: Employee Recruitment	6,374
Health Care Worker Background Check	1,226
(Indicate # of checks performed 92)	
Illinois Health Care Association	5,400
less 32.97% lobbying costs	(1,780)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,000

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,177
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,177

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Parents & Friends of the SLC # 0026773 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association, $5400**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,038** Line **10/2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **Yes**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **229,476**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **61,473** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **99%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Rice Sullivan and Co., Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yed** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Yrs	Accumulated Depreciaiton
Patient Care	1979 Ford Truck	1982	4,500				5	4,500
Patient Care	Snow Plow	1982	1,465				5	1,465
Patient Care	1988 Tractor	1988	8,356				5	8,356
Patient Care	1990 Van w/ w/c lift	1991	19,034				4	19,034
Patient Care	wheelchair lift	1991	2,885				4	2,885
Patient Care	1993 Plymouth Van	1993	14,547				4	14,547
Patient Care	1997 Riding Mower	1997	1,000				5	1,000
Patient Care	2002 Riding Mower	2002	1,033	207	207		5	551
Patient Care	2003 Riding Mower	2003	2,577	644	644		4	1,074
Patient Care	1993 Ford Van	2003	16,983	4246	4246		5	5,661
Patient Care	1991 E150 Ford Van	2004	2,150	0	0		3	-
Patient Care	1994 Dodge Caravan	2004	2,150	0	0		4	-
			76,680	5097	5097			59,073